Republic of the Philippines
Department of Health
Philippine Health Insurance Corporation *and*
Research Institute for Tropical Medicine
Antimicrobial Resistance Surveillance Program

APPLICATION FOR ARSP ACCREDITATION OF BACTERIOLOGY LABORATORY

PART I: HOSPITAL INFORMATION

Date of Application: *(mm/dd/yyyy)*		Status of Application: *(select appropriate)*		New		Renewal
Name of Hospital/Health Facility:						

Address:			
	Number	*Street*	*Barangay*
	Municipality/City	*Province*	*Region*	*Zip Code*

Telephone No:		BHFS License Permit No:	
Facsimile No:		Validity Date: *(mm/dd/yyyy)*	

Classification according to: *(select appropriate)*					
	Ownership:		Government		Private
	Function:		General		Special
	Capability:		Level 1		Level 2
			Level 3		Level 4

Name of Hospital Director/Chief:			
	Last Name	*First Name*	*M.I.*

PART II: LABORATORY INFORMATION

A. Name of Laboratory:					
Classification according to Function: *(check appropriate)*		Clinical Pathology		Anatomical Pathology	

Telephone No:		Telephone No*(Direct Line):*	
Facsimile No:		Email Address:	

B. Head of Laboratory			
	Last Name	*First Name*	*M.I.*

Date of Certification by Society of Pathology: *(mm/dd/yyyy)*	

Name of specialty board: *(check appropriate)*		CP		AP-CP		others (specify)	

STAFFING

Laboratory Staff	Name	Position Title	Educational Attainment	PRC No./ Validity
1. Bacteriology Supervisor				
2. Medical Technologist				

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PART III: BACTERIOLOGY LABORATORY SERVICES

TEST *(check appropriate)*	(✓) if done
1. Gram's Staining	
2. Culture *(Isolation and Identification)*	
3. Susceptibility Testing	
4. Others, *(specify)*	

PART IV: FEES

Accreditation Fee: *(Non-refundable)*				**Php 7,000.00**
Mode of Payment: *(select appropriate)*		Cash: *(RITM Cashier)*		*OR Number*
		Check: *(Payable to* **Research Institute for Tropical Medicine***)*		*OR Number*
		Check Number	*Bank/Branch*	*Date (mm/dd/yyyy)*

Note: *If you do not receive an acknowledgement receipt within 3 weeks after submission of application form, please call ARSRL office at* ***(02) 809-9763*** *or* ***(02) 807-2630 local 243.***

PART V: DECLARATION

I hereby certify that the foregoing statements are true. I hereby submit this application for accreditation under Antimicrobial Resistance Surveillance Program and agree to comply with the rules and regulation of ADMINISTRATIVE ORDER NO. 2015-0049.

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Name in Print and Signature	Date
Designation	PTR